LETTERS TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Bettina.Klar@rcplondon.ac.uk.

Thrombolysis nurse

Editor – Somauroo *et al* have improved the care of patients with acute myocardial infarction by employing a thrombolysis nurse in the accident and emergency department (January/February 1999, pp 46–50). We do, however, have some concerns about the validity of their conclusions and the extent to which they should be generalised.

Failure to allocate care randomly to a time when the thrombolysis nurse was present or absent may overestimate the effects of the thrombolysis nurse. The differences between the patients treated when the thrombolysis nurse was present and those treated at other times may be due, at least in part, to other differences in staffing levels and seniority. Including pain to needle time as an outcome seems illogical since the thrombolysis nurse could not be expected to shorten the 'pain to call' time.

The cost effectiveness discussion may be based on an extreme estimate of the impact of decreased door to needle times. The calculations of cost per additional life saved are based on the estimate from the GREAT[1] study of 26 additional survivors per thousand patients thrombolysed one hour earlier. Another estimate (based on a number of large studies)[2] is much lower and demonstrated just 1.6 additional survivors per thousand patients treated one hour earlier.

Finally, the authors did not consider other ways in which the resources needed for a thrombolysis nurse might be deployed within an accident and emergency department. In our department a combination of training, audit and feedback, and a shared commitment to improving the care of patients with acute myocardial infarction has increased the proportion of patients with definite myocardial infarction thrombolysed within 30 minutes of arrival to 58%.

References

1 Rawles J. Magnitude of benefit from earlier thrombolytic treatment in acute myocardial infarction: new evidence from the Grampian Region Early Anistreplase Trial (GREAT). *Br Med J* 1996;**312**:212–5.

2 Fibrinolytic Therapy Trialists' (FTT) Collaborative Group. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet* 1994;**343**:311–22.

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Thrombolysis in inferior myocardial infarct – unhelpful?

Editor – I enjoyed the article by Danna and Walker (March/April 1999, pp 131–40). In it they again raised the doubt about the benefit of thrombolysis in inferior myocardial infarcts[1]. We recently had two patients presenting with inferior myocardial infarcts when some doubt existed about thrombolysis – but despite that, thrombolysis was given with more harm than good being done. I believe that airing this issue will remind physicians about the marginal benefit of thrombolysis in inferior myocardial infarct and encourage them to reconsider its use in doubtful circumstances.

Reference

1 Tobe TJM. Is thrombolytic therapy in acute inferior myocardial infarction really better than conventional treatment. *Br Heart J* 1995;**73**:108–9.

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A training course for the UEB examination

Editor – I am pleased to hear that the Privy Council has reversed the decision of the GMC to abolish the United Examining Board (UEB) examination.

I believe that this examination is valuable, and that a fair, high and consistent standard is set by examiners. We, as UEB examiners, are given no opportunity to pass candidates who are having a bad or 'off' day on the day of the examination.

It is vital that the candidates who appear for the UEB are adequately prepared, and carefully selected for suitability. The hard work and careful screening, teaching, coaching and mock examination of students at St George's – apparent from the paper presented by Eastwood *et al* (March/April 1999, pp163–7) – is a very good model and clearly the St George's course is a leading example of how such pre-UEB training should be conducted.

The PLAB examination is, in some ways, flawed and I believe the GMC should make changes. I am also pleased that the Privy Council has instructed the GMC to work with the United Examining Board to make some changes in the UEB exam itself.

In summary, I would like to support the continuation of the UEB examination and encourage the development of courses at medical schools, and other academic medical institutions, similar to that which has been in operation at St George's hospital.

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Cyberclinic in rheumatology

Editor – Dr Pal describes the potential benefits of e-mail based consultations for new referrals (March/April 1999, pp161–2), and in a previous publication promotes the use of telephone consultations for rheumatology follow-up appointments[1]. These developments are, it seems, popular with patients and may appear attractive to health purchasers and providers. They also generate